



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

INNOVA HOSPITAL SAN ANTONIO  
4243 E SOUTHCROSS BLVD  
SAN ANTONIO TX 78222-3727

#### **Respondent Name**

VIA METROPOLITAN TRANSIT

#### **Carrier's Austin Representative Box**

Box Number 16

#### **MFDR Tracking Number**

M4-10-4283-01

#### **MFDR Date Received**

June 4, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital no choice but to seek medical fee dispute resolution."

**Amount in Dispute:** \$33,950.26

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Outpatient Hospital Facility Fee Guideline DWC rule 134.403 does not contain a provision for stop loss threshold... The position statement from the provider requested implants to be separately reimbursed. Therefore, the prior reimbursement for implants was \$2,439.80, which included the 10% markup and \$3,879.59 for the Medicare portion, which included a markup of 130%... At this time we are recommending an additional allowance of \$1,453.69 for the Medicare portion. "

**Response Submitted by:** Argus Services Corporation 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243-2055

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2009	Outpatient Hospital Services	\$33,950.26	\$6,192.26

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 97H – Payment is included in the allowance for another service/procedure. \*Service(s) / Procedure is included in the value of another service/procedure billed on the same date.\*
  - W1KA – Workers Compensation State Fee Schedule Adjustment\*Reimbursement per the Hospital Facility Fee Guideline-Outpatient Rule 134.403.\*
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. For the purpose of calculating outlier payments, per §134.403(f)(2), the facility's total billed charges shall be reduced by the billed charges for any implantable items that are separately reimbursed.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 99070 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Per Medicare policy, payment for this service is always bundled into payment for other services performed on the same date. Separate payment is not recommended.
  - Procedure code 82947 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.73. 125% of this amount is \$7.16. The recommended payment is \$7.16.
  - Procedure code 82310 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$7.53. 125% of this amount is \$9.41. The recommended payment is \$9.41.
  - Procedure code 82435 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$6.70. 125% of this amount is \$8.37. The recommended payment is \$8.37.

- Procedure code 82565 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$7.48. 125% of this amount is \$9.35. The recommended payment is \$9.35.
- Procedure code 84132 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$6.70. 125% of this amount is \$8.37. The recommended payment is \$8.37.
- Procedure code 84295 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$7.02. 125% of this amount is \$8.77. The recommended payment is \$8.77.
- Procedure code 84520 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.76. 125% of this amount is \$7.20. The recommended payment is \$7.20.
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.46. 125% of this amount is \$4.33. The recommended payment is \$4.33.
- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.46. 125% of this amount is \$4.33. The recommended payment is \$4.33.
- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,950.67. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of \$1,739.41. The non-labor related portion is 40% of the APC rate or \$1,300.44. The sum of the labor and non-labor related amounts is \$3,039.85. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.308. This ratio multiplied by the billed charge of \$9,800.00 yields a cost of \$3,018.40. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$3,039.85 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$6,573.99. The allocated portion of packaged costs is \$6,573.99. This amount added to the service cost yields

a total cost of \$9,592.39. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$4,272.65. 50% of this amount is \$2,136.33. The total APC payment for this service, including outliers and any multiple procedure discount, is \$5,176.18. This amount multiplied by 130% yields a MAR of \$6,729.03.

- Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include: "LUPINE BR ANCHOR W/DS ORTH" as identified in the itemized statement and labeled on the invoice as "LUPINE BR DS W/ORTHCRD" with a cost per unit of \$334.00 at 2 units, for a total cost of \$668.00; "5.5 HEALIX BR ANCHORW/ORTHCORD" as identified in the itemized statement and labeled on the invoice as "5.5 HEALIX BR ANCHOR W/ORTHOCORD -EO" with a cost per unit of \$350.00; "PLATCHET GEL" as identified in the itemized statement and labeled on the invoice as "Platlet GEL" with a cost per unit of \$4,200.00. The total net invoice amount (exclusive of rebates and discounts) is \$5,218.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$521.80. The total recommended reimbursement amount for the implantable items is \$5,739.80.
4. The total recommended payment for the services in dispute is \$12,536.12. Review of the submitted documentation supports that the insurance carrier has made payment to the requestor in the amount of \$6,343.86. Although the respondent's position statement asserts that "At this time we are recommending an additional allowance of \$1,453.69 for the Medicare portion", no documentation was received from either party to support that an additional payment was sent to, or received by, the requestor. Accordingly, the total recommended payment for the disputed services of \$12,536.12 less the amount previously paid by the insurance carrier of \$6,343.86 leaves an amount due to the requestor of \$6,192.26.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$ 6,192.26.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$ 6,192.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

<hr style="border: none; border-top: 1px solid black;"/>	<b>Grayson Richardson</b>	<b>September 14, 2012</b>
Signature	Medical Fee Dispute Resolution Officer	Date

<hr style="border: none; border-top: 1px solid black;"/>	<b>September 14, 2012</b>
Signature	Medical Fee Dispute Resolution Manager

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**